STATE OF IOWA DEPARTMENT OF CORRECTIONS POLICY AND PROCEDURES		Policy Number FPH-31	Applicability ☒ DOC ☐ CBC
		Policy Code Confidential	Iowa Code Reference 904, 812, 229
Chapter 10 FORENSIC PSYCHIATRIC HOSPITAL	Sub Chapter TREATMENT	Related DOC Policies IO-SC-08, IO-SC-12, IO-SC-28, HSP-609, HSP-720	Administrative Code Reference 481
Subject USE OF RESTRAINTS		ACA Standards 4-4191	Responsibility Warden Jim McKinney Dr. Harbans Deol
		Effective Date May 2016	Authority Jerry Bartruff Director Signature on file at Iowa DOC

I. PURPOSE

The purpose of this policy is to describe the uses for restraint and the procedures that need to be followed in order to comply with national standards of care.

II. POLICY

To ensure that the use of restraints are appropriately utilized, assessed properly, medically authorized, proper notifications are made, reassessed, released, documented and debriefed in accordance with nationally accepted standards of care. Restraints may only be used when less restrictive interventions have been determined to be ineffective to protect the patient from him/herself and/or others from harm. The type or technique of restraint used must be the least restrictive intervention and discontinued at the earliest possible time, balanced with the continuing need to effectively protect the patient and/or others from harm.

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III. DEFINITIONS

A. Restraints - Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head, freely.

B. See IDOC Policy **AD-GA-16** for additional Definitions.

IV. PROCEDURE

A. Acceptable Uses of Restraints

1. A patient may be so impaired and/or assaultive that the use of restraints is required to reduce the risk of injury or harm to the patient and/or others.

2. Restraints may be used when alternative measures, time and circumstance permitting, have been tried and failed. (See DOC **HSP-720**, *Health Care Restraints* for alternatives, communication and de-escalation techniques).

3. Restraints will only be used to the degree necessary and the least restrictive to prevent injury to the patient and/or others.

B. Initial Assessment

1. Prior to the application of restraints or within one hour following the immediate need to place a patient in restraints, a member from the medical staff (physician, psychiatrist, RN) will conduct a face-to face assessment. This assessment will include:

   a. The behavior that warrants the use of restraints;

   b. The patient's immediate situation and location;

   c. The patient's reaction/response to restraints, if implemented;

   d. The patient's medical conditions that may contraindicate the safe use of restraints;

   e. Any alternative interventions that have been utilized and/or failed in an attempt to avoid the use of restraints

   f. The restraint recommended for use;

   g. The need to continue or terminate the restraint.

2. Once the restraints have been applied, the initial assessment by the RN will also include:

   a. Restraint placement should not be so tight as to compromise circulation of extremities or impede respiration. Assessment includes:

      (1.) Pulses present distal to restraints;

      (2.) Capillary nail refill test (normal is less than three seconds);

      (3.) Color and temperature of skin (should be warm and without cyanosis)

      (4.) Restraint should have two fingers space for the chest.

   b. Assess for signs which require immediate medical attention which include:

(1.) Respiratory distress;

(2.) Vomiting;

(3.) Change/loss of consciousness.

3. This initial assessment is to be documented in the patient's hospital medical record. If the ordering physician is not present, the RN must verbally communicate the assessment to the physician by telephone.

C. Orders for the Use of Restraints

1. A physician's verbal, telephone or written order will be obtained prior to or within one hour after the application of restraints.

2. PRN or "as needed" orders for restraint are prohibited.

3. All restraint orders shall be for the least amount of time necessary to prevent injury to the patient or others.

4. In some situations, an MHO or SSIP order will accompany the order for restraints.

[redacted]

6. All other restraint orders [redacted] may be written for up to a maximum of 24 hours.

7. Any continued use of restraint longer than 24 hours requires a complete face-to-face assessment by a physician or a registered nurse and a new order obtained. If a physician is on-site, the physician will complete the face-to-face assessment.

8. All orders received verbally or by telephone must be signed by the attending physician on the next working day. This will include date and time of signature.

9. Restraint orders must include:

a. Date/time of order;

b. Type of restraint;

c. Reason for use (actual behavior of patient or patient request);

d. Length of time to be used [redacted]

D. Notifications

1. The Shift Supervisor will be informed prior to the planned application of restraints.

2. The Shift Supervisor will be notified as soon as possible after the reactive application of restraints.

E. Reassess the Use of Restraints

1. Regardless of the type of restraint, continuous assessment must occur to determine when the patient can safely be removed from restraints at the earliest possible time.

[redacted]

3. For all other types of restraints that are ordered for a maximum of 24 hours, a thorough reassessment by the nurse of the condition of the patient is conducted every four hours to determine the need for ongoing restraint and to monitor the health and safety of the patient. At 24 hours, the physician or Registered Nurse is to provide a documented face-to-face assessment and determine the need for a new order.

4. While in restraints vital signs will be taken at least once per shift and documented.

5. A nursing assessment and documentation must occur every four hours following the initial placement of restraints and include:

a. The patient's behavior and reactions to being in restraints;

b. Describe any other interventions being provided to expedite removal from restraints such as dialogue, calming music, etc.;

c. Time of last meal;

d. Circumstances associated with placement in restraints to identify any additional assessment needed. (A physical altercation with another patient may require a more extensive assessment for possible injury. A physician may need to be contacted to determine if restraint placement should continue);

e. Upon questioning by the Registered Nurse, any patient self-reports of discomfort, injury, nausea, difficulty breathing, numbness or tingling;

f. Restraint placement should not be so tight as to compromise circulation of extremities or impede respiration. Assessment of circulatory adequacy includes:

(1.) Pulses present distal to restraints;

(2.) Capillary nail refill test (normal is less than three seconds);

(3.) Color and temperature of skin (should be warm and without cyanosis);

(4.) Restraint should have two fingers space for the chest;

g. Assess for signs which require immediate medical attention which include:

(1.) Respiratory distress;

(2.) Vomiting;

(3.) General circulatory compromise system-wide, not just distal to restraints;

(4.) Change/loss of consciousness.

F. Release from Restraints

1. Psychiatrists, Medical Practitioners, and Registered Nurses have the authority to discontinue restraints.

2. After evaluation, a Registered Nurse may discontinue the use of restraints at any time if the patient is calm and displaying appropriate behavior.

[redacted]

4. After removal of restraints, the Shift Supervisor and physician will be notified.

5. Temporary removal of restraints are allowed when the patient needs to use the bathroom and for meals. The decision to allow temporary removal of restraints for bathroom and eating is assessed by the nurse and other team members to determine the potential for harming themselves or others.

G. Documentation

1. The order for restraint use will be supported by objective data and include a specific plan, which will be documented in the patient's hospital medical record with a written order signed by the physician on the next administrative day.

2. Medical staff will review and sign when they make patient contact on the *Observation/Restraint/Seclusion Log* **(FPH-31 F-1)**.

3. Security staff will make an entry in the unit log. These entries should be as detailed and specific as to the behavior that justified the action taken.

[redacted]

a. Meals served or refused at all regularly scheduled meal times;

b. Toilet was available and toilet used when a patient completes this activity;

c. Water was provided at least every hour in the event a patient does not have continuous access to water.

5. Nursing shall document their initial assessment and all reassessments every shift. The elements included in the nursing assessment are defined under Initial Assessment and Re-assessment.

6. If a physician is on-site, they are expected to provide the face-to-face assessment establishing the need for restraint. This would be documented in the hospital medical record. If the physician is not on-site, the trained Registered Nurse shall provide the assessment.

[redacted]

8. Psychiatry, Medical Practitioner and/or nursing staff are to be notified of any significant changes in behaviors and/or concerns that are noted by staff while in restraint.

9. When restraints are removed, a detailed note which communicates the behaviors present will be made by the Registered Nurse in the hospital medical record.

H. Debriefing

1. A debriefing with the patient should be conducted within 24 hours following the release from restraint.

2. The RN Supervisor or designee will complete the *Debriefing form* **(FPH-32 F-1)**.

I. Types and Application of Restraints

[redacted]

[redacted]

a. These devices are not intended for use as a standard restraint.

b. Special restraints may be used for a patient who has demonstrated such physically aggressive or unmanageable behavior that regular restraints are not adequate to control his/her behavior.

c. Special restraints include:

[redacted]

(4.) A nursing supervisor must be notified when special restraints are utilized.

[redacted]

12. Protective measures for medical conditions – Used in association with medical conditions where other adaptive or assistive devices are inadequate to enable a patient to maintain posture, prevent injury to self, or to achieve other medical purposes. [redacted]

[redacted]

[redacted]

[redacted]

d. Other devices which restrict freedom of movement or access to one's body in order to prevent falls, maintain posture or other medical purposes.

J. Restrictions While in Restraints

1. Patients in restraints will be restricted to the unit unless otherwise noted by a physician order or the patient's treatment plan.

2. Patients will be restricted from work duties, recreational and/or physical activities on which rapid movements are required and the safety hazards they impose.

K. Removal and/or Modification of Restraints in the Event of an Emergency

[redacted]

[redacted]

L. Additional Safety Measures

1. A spit mask may be used temporarily to prevent a patient from spitting on staff during transport or while in direct contact.

2. A soft helmet with an adjustable chin strap may be used to prevent patients from self-injurious behavior. If a shield is on the helmet, there must be air holes for ventilation. Some helmets may include a bite bar.